

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2748

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02736

Reg. Dist. No. 190

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #4 Box 33</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. #4 Box 33</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Nelson Atwell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 11 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10, 1863</u>
9. AGE last birthday <u>91</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cheluron</u>	
11. BIRTHPLACE (State or foreign country) <u>Huntington Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Fletcher Atwell</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Wilkinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>290-07-1949</u>	
17. INFORMANT AND ADDRESS <u>Box 33 AR R 284</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carcinoma of tongue & parathyroid glands</u>		<u>2 yrs</u>	
Antecedent cause(s) (b) <u>Sarcinoma</u>		<u>10 yrs</u>	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Mar 11</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>Mar 10</u> , 19 <u>55</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. B. B. Brumbaugh</u>		ADDRESS <u>1609 Main St. Elkridge 27 Md</u>	
DATE SIGNED <u>3/11/55</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3/14/55</u>	
NAME OF CEMETERY OR CREMATORY <u>GRACE EPIS.</u>		LOCATION (City, town, or county) (State) <u>ELKRIDGE, Md</u>	
DATE REC'D BY LOCAL REG. <u>March 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Dr. R. D. Kilgus</u>	
24. FUNERAL DIRECTOR <u>F.C. HIGGINS</u>		ADDRESS <u>1307 HON, ELLICOTT CITY, Md</u>	

BUREAU V. S.

MAR 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

2749

02737

1. PLACE OF DEATH COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Columbia Road		STREET ADDRESS (If rural, give location) Columbia Road	
3. NAME OF DECEASED (First) ADAM (Middle) P (Last) BARRETT		4. DATE OF DEATH (Month) 3-4 (Day) 1955 (Year) 19	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-6-1882
9. AGE last birthday 72 yrs.		10. BIRTHPLACE (State or foreign country) Oldham, Lancashire, England	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Barrett		14. MOTHER'S MAIDEN NAME Martha Buckley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Mrs. A.K. Barrett, Ellicott City, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Coronary Occlusion**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

Acute

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jan 1, 1940**, to **March 4, 1955**, that I last saw the deceased alive on **March 4, 1955**, and that death occurred at **10:20 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3-7-55	NAME OF CEMETERY OR CREMATORY New Cathedral	LOCATION (City, town, or county) Baltimore, Md	(State)
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DATE REC'D BY LOCAL REG March 6, 1955	REGISTRAR'S SIGNATURE John B. Longman	24. FUNERAL DIRECTOR F.C. Higinbotham	ADDRESS Ellicott City, Md
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Pu. B. E. L.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 9 1913

RECEIVED

2750

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Elbridge</u>		<u>33 yrs</u>		TOWN <u>Elbridge</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				<u>44 Hunt Club Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>LEONHARD</u> <u>BUETTNER</u>				<u>March 29 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>Jan. 24, 1867</u>	<u>88</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Baker</u>		<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Buettner</u>				<u>Eva Doener</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
<u>9 -</u>		<u>no -</u>		<u>44 Hunt Club Rd, Mrs Marie W. Herzog Elbridge 27, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
<u>153X</u>				<u>2 yrs</u>			
Immediate cause				<u>3 mos.</u>			
(a) <u>Carcinoma of Colon</u>				<u>6 mos.</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				<u>2 mo</u>			
(b) <u>Metastatic</u>							
(c) <u>Secondary anemia</u>							
<u>Myocarditis</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>10 yrs</u>			
<u>Smility</u>							
19a. DATE OF OPERATION:				20. AUTOPSY?			
<u>0</u>				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
19b. MAJOR FINDINGS OF OPERATION							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Jan 1954</u> , to <u>March 29 1955</u> , that I last saw the deceased alive on <u>March 29 1955</u> , and that death occurred at <u>8:45 a.m.</u> from the causes and on the date stated above.							
SIGNATURE (Degree or title)				DATE SIGNED			
<u>Dr. B. B. Cunningham</u>				<u>3/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 1, 1955</u>		<u>London Park Cemetery</u>		<u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 29 1955</u>		<u>Dr. B. B. Cunningham</u>		<u>Henry W. Jenkins & Sons, Co.</u>		<u>4905 York Rd, Baltimore Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 31 1955

BUREAU V. S.

2751

03731

Reg. Dist.

Item 21 Film 1001 5-1-55 Ans 2751 MD. DEPT. OF HEALTH - BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HOWARD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rural--Mt. Airy</u>		<u>06X-2</u>	
TOWN <u>Poplar Springs</u>				STREET ADDRESS (If rural, give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>LUCY</u> (Middle) <u>BOWIE</u> (Last) <u>BURNS</u>				(Month) <u>3</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		
<u>female</u>	<u>colored</u>	<u>married</u>	<u>6-10-1881</u>	<u>73</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>own home</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Kale Potts</u>				<u>Amelia Hosley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>none</u>		<u>John Burns, Mt. Airy, Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
812X Immediate cause (a) <u>Crushed Chest Rupture of</u>							
Antecedent cause(s) (b) <u>Diaphragm</u> <u>Massive internal</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Hemorrhage</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Street</u>		21c. (City or town) (County) (State)			
<u>Poplar Springs</u> <u>Howard</u> <u>Maryland</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/19/55</u> <u>7:45 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by h2 and run car.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William J. Wood</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>3-20-55</u>	
		M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL - CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-22-1955</u>		<u>Friendship</u>		<u>Montg. Co., Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 22, 1955</u>		<u>W. J. Wood</u>		<u>C. M. Waltz</u>		<u>Winfield, Md.</u>	

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

APR 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02739

2752

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Ellicott City		LENGTH OF STAY (in this place) 70 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Columbia Road				STREET ADDRESS (If rural give location) Columbia Road		1	
3. NAME OF DECEASED (First) JAMES		(Middle) CLARK		(Last)		4. DATE OF DEATH (Month) March (Day) 25 (Year) 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH October 22, 1884.		9. AGE last birthday 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY General Law		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John L. Clark				14. MOTHER'S MAIDEN NAME Mary Corinne Talbott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. James Clark,		Columbia Road, Ellicott City, Md.	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) Myocardial failure, congestive			months
Antecedent cause(s) (b) Pulmonary emphysema			years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) arteriosclerosis of coronary arteries			years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Papilloma urinary bladder			years
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from January 1955, to March 1955, that I last saw the deceased alive on March 24, 1955, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE Donald E. Fisher M.D. (Degree or title) ADDRESS Ellicott City, Md. DATE SIGNED March 26, 1955

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Mar. 27, 1955 NAME OF CEMETERY OR CREMATORY St. John's Cemetery LOCATION (City, town, or county) (State) Ellicott City, Md.

DATE REC'D BY LOCAL REG March 26, 1955 REGISTRAR'S SIGNATURE John B. Loughran 24. FUNERAL DIRECTOR Easton Sons, Ellicott City, Md. ADDRESS

Rev. B. E. L.

MARGIN RESERVED FOR BINDING

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RECEIVED

MAR 29 1955

BUREAU V. S.

2753

MARYLAND STATE DEPARTMENT OF HEALTH

02740

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 191

1. PLACE OF DEATH - COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. (13)</u>	
TOWN <u>ELLICOTT CITY</u> LENGTH OF STAY (in this place) <u>7mo.</u>		TOWN <u>BALTO. (13)</u> 3V. 1-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HIGHLAND MANOR HOME</u>		STREET ADDRESS (If rural, give location) <u>3313 HAYWARD AVE</u>	
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>T.</u> (Last) <u>CHARKE</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>31</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Nov-? -1869</u>
9. AGE last birthday <u>85</u> yrs.		10. AGE last birthday (If under 1 year) Months <u>3</u> Days <u>31</u> Hours <u>1</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Trainer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RACING</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. T. CLARK, SR.</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN (?)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>MRS. LUCY HOPSON</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>447X</u> (a) <u>Generalized arteriosclerosis, cerebral degeneration and hypertension</u>		<u>5 years</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, and an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Robert B Taylor MD</u> (Degree or title)		ADDRESS <u>Ellicott City Md.</u> DATE SIGNED <u>3-31-55</u>	
23. BURIAL, CREMATION, or other disposal (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>4-2-55</u>	<u>ROSEDALE & LINDEN CEM.</u>	<u>LINDEN, N.J.</u>
DATE RECD BY LOCAL REG. <u>4/4/55</u>	REGISTRAR'S SIGNATURE <u>John Loughran</u>	24. FUNERAL DIRECTOR <u>Walter Burke Bradley, Linc. Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2754

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

112741

Reg. Dist. No. 11

1. PLACE OF DEATH— COUNTY <u>Howard</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u> <input checked="" type="checkbox"/> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Simon's Rest Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE _____ COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> OR TOWN STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u> (First) <u>Duncan</u> (Middle) <u>Duncan</u> (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 30, 1873</u>
9. AGE last birthday <u>81</u> yrs. If under 1 year Months _____ Days _____		10. BIRTHPLACE (State or foreign country) <u>Scotland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Andrew G. Duncan</u>		14. MOTHER'S MAIDEN NAME <u>Grace Milne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT AND ADDRESS <u>RECORDS - SIMON'S REST HOME</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> Immediate cause (a) <u>Uremia</u> Antecedent cause(s) (b) <u>Nephritis, Myocarditis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cardio-vascular</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>3/10/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>L</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>L</u>		PLACE (Home, farm, factory, street, office bldg., etc.) _____ (CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____	
TIME (Month) (Day) (Year) (Hour) _____ OF INJURY _____ m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>3/10/55</u> , 19 <u>55</u> , to <u>3/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/23/55</u> and that death occurred at <u>3 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u> (Degree or title)		ADDRESS <u>Sandy Spring Md.</u> DATE SIGNED _____	
23. BURIAL OR CREMATION (Specify) <u>Buried</u> DATE THEREOF <u>3/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine</u> LOCATION (City, town, or county) <u>Balto. Co. Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-28-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u> FUNERAL DIRECTOR <u>Wm. G. McKee</u> ADDRESS <u>1217 St. Paul st</u>	

2755

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Jessup</u>		<u>2 yrs</u>		TOWN <u>Jessup</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Louise</u> <u>Jannon</u>				<u>March 2</u> <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>August 6, 1886</u>	
9. AGE last birthday: <u>68</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.		11. BIRTHPLACE (State or foreign country): <u>Jessup Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION..Give kind of work done during most of working life, even if retired): <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Jessup Maryland</u>	
13. FATHER'S NAME: <u>William Harman</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Layman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>if no</u>				16. SOCIAL SECURITY No.: <u>---</u>			
17. INFORMANT & ADDRESS: <u>Mr. Clarence B. Jannon, Jessup Md</u>				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
443X Immediate cause (a) <u>Ac. Cerebral-Vascular Accident -</u>				30 min.			
Antecedent causes (s) (b) <u>Hypertensive Cardio-Vascular Disease</u>				3 yrs.			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)		24. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Oct. 1952</u> to <u>March 2, 1955</u> , that I last saw the deceased alive on <u>Mar. 2, 1955</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above,							
SIGNATURE <u>Frank Shipley, M.D., Savage, Md.</u>				DATE SIGNED <u>Mar. 5, 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 5, 1955</u>		<u>Madam and Ben Park</u>		<u>Lansing Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/4/55</u>		<u>E. Bird Williams</u>		<u>Dr. With Hamilton, Laurel Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 8

BUREAU V. S.

MARYLAND

2756

02743

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Seabrookville</u> LENGTH OF STAY (in this place) <u>10 yrs</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Seabrookville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waverly R. & W.</u>				STREET ADDRESS (If rural, give location) <u>Waverly R. & W.</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Sarah</u> (Middle) <u>Louise</u> (Last) <u>Jones</u>		4. DATE OF DEATH		(Month) <u>March</u> (Day) <u>22</u> (Year) <u>1954</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 4, 1880</u>	9. AGE last birthday <u>74 yrs.</u>	If under 1 year: Months <u>1</u> Days <u>22</u> Hours <u>19</u> Min. <u>55</u>		If under 24 hrs: Hours <u>19</u> Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. W. C. Clinton Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pamel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)				16. SOCIAL SECURITY No. <u>None</u>			
17. INFORMANT AND ADDRESS <u>Miss Hazel Jones, 1044 1/2 W. 1st St., Md.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443x Immediate cause (a) <u>Hypertensive Cardiovasc. Dis. with Myocardial Failure</u>				10 yrs.			
Antecedent cause(s) (b) <u>Transverse Myelitis from Arthritis 12 D & L 1 Vertebra</u>				1 yr.			
Diseases or conditions, if any, giving rise to the above, and stating the underlying cause: <u>Chr. Nephritis, Obesity</u>				5 yrs.			
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>11/1/54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Destruction 12 D & L 1 - Osteoarth.</u>		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/12/54</u> to <u>3/22/55</u> , that I last saw the deceased alive on <u>3/21/55</u> , and that death occurred at <u>8:30 A</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Dr. W. Warren Jones</u>		(Degree or title)		ADDRESS <u>3/22/55</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Seabrookville</u>		LOCATION (City, town, or county) (State) <u>Seabrookville, Howard, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 25-55</u>		REGISTRAR'S SIGNATURE <u>Frank Shipley</u>		24. FUNERAL DIRECTOR <u>Seabrookville</u>		ADDRESS <u>Seabrookville, Howard, Md.</u>	

BORLAV V. B.

1955

RECEIVED

2757

MARYLAND STATE DEPARTMENT OF HEALTH

02744

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH: COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 Columbia Road		STREET ADDRESS 60 Columbia Road	
3. NAME OF DECEASED (Type or Print)	(First) MILDRED	(Middle) H.	(Last) GRAHAM
6. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec. 24, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Mach. Opr.		10b. KIND OF BUSINESS OR INDUSTRY Sewing Factory	9. AGE last birthday 61 yrs.
11. BIRTHPLACE (State or foreign country) Ellicott City Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Arthur B. Graham		14. MOTHER'S MAIDEN NAME Nellie Louise Beatty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-0695	
17. INFORMANT AND ADDRESS Mrs. Clark Meads, Ellicott City, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1857 Immediate cause (a) **Carcinoma of Gall Bladder**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

11a. DATE OF OPERATION **12/29/55** 11b. MAJOR FINDINGS OF OPERATION **Metastatic Carcinoma of liver and pancreas**

19a. DATE OF OPERATION

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

INJURY

HOW DID INJURY OCCUR?

TIME (Month) (Day) (Year) (Hour)

OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

22. I hereby certify, that I attended the deceased from **3/29**, 19**55**, to **3/13**, 19**55**, that I last saw the deceased

alive on **3/13**, 19**55**, and that death occurred at **2:30** a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 15, 1955 **John B. Loughran**

F.C. Higinbotham, Ellicott City, Md

P. B. E. L.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

2758

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>ELLICOTT CITY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> <u>03-52-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 SHAFFERS CONALESCENT HOME</u>		STREET ADDRESS (If rural, give location) <u>WESTCHESTER AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>THERESA</u>	(Middle) <u>CECILIA</u>	(Last) <u>HOLDEN</u>
4. DATE OF DEATH	(Month) <u>MAR.</u>	(Day) <u>3</u>	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>SEPT 2, 1870</u>
9. AGE last birthday <u>84</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPER</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CONRAD L. ELLS</u>		14. MOTHER'S MAIDEN NAME <u>NO KNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Charles D. Holden 4610 Maryland Rd.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>422.1 Coronary Thrombosis</u>		<u>1/2 hour</u>
(b) Antecedent cause(s) <u>Hypertensive Cardio-Vascular Disease</u>		<u>5 years</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1950, to Mar 3, 1955, that I last saw the deceased alive on March 1, 1955, and that death occurred at 9:30 A. m., from the causes and on the date stated above.

SIGNATURE <u>William F. Hassaway</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Ellicott City, Md.</u>	DATE SIGNED <u>3/3/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>March 10, 55</u>	REGISTRAR'S SIGNATURE <u>John B. Loughran</u>	24. FUNERAL DIRECTOR <u>Fowler Funeral Home - Catonsville, Md.</u>	ADDRESS
<u>Rev. B. E. L.</u>			

CERTIFICATE OF DEATH

2759

Reg. Dist. No. 192

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Howard		STATE		Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Ellicott City		COUNTY			
TOWN				CITY (If outside corporate limits, write RURAL and give nearest town)		Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
Highland Manor Nursing Home				632 Willow Avenue			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
Mr.		John E.		Lewis		March 20th 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
male		white		divorced		Sept. 7, 1878	
9. AGE last birthday:		10. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
76 yrs.		Printer		Baltimore, Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Mr. John E. Lewis				Julia Fales			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
(If Yes, give war or dates of service)						Mr. Charles E. Lewis, 632 Willow Ave.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <i>Cerebral Thrombosis with left</i>							
Antecedent causes (s) (b) <i>Hemiplegia</i>						6 weeks	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)			
SUICIDE				INJURY			
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)				INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF INJURY				While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 3-9-55, to 3-20-55, that I last saw the deceased alive on 3-19-55, and that death occurred at 8:15 AM, from the causes and on the date stated above.							
SIGNATURE				(Degree or title)		ADDRESS	
<i>Julia B. Taylor MD</i>				<i>Ellicott City Md</i>		DATE SIGNED	
3-21-55							
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				Marc. 23, 1955		Parkwood Cemetery	
LOCATION (City, town, or county) (State)				Baltimore, Maryland			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
3-22-55				<i>H. W. DeLong</i>		ADDRESS	
						Leonard J. Ruck, 5305 Harford Road #14	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Robert Taylor
700 Cathedral Street
Monday 3 P.M, Office.

MARYLAND 2760

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY <u>Harford</u> - MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> OR TOWN <u>Beltsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>31-1-4</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> OR TOWN <u>Baltimore City</u> STREET ADDRESS (If rural, give location) <u>413 S. Towner St</u>	
3. NAME OF DECEASED (Type or Print) <u>Hermon</u> (First) <u>Carl</u> (Middle) <u>Ward</u> (Last)	4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1955</u>	5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH Month <u>Jan</u> Day <u>12</u> Year <u>1918</u> Age <u>43</u> yrs.	9. AGE last birthday If under 1 year: Months <u>25</u> Days <u>19</u> Hours <u>55</u> Min.	10. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Driver</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>John Ward</u>	14. MOTHER'S MAIDEN NAME <u>Kitchen Paul</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>218-09-0190</u>	16. SOCIAL SECURITY NO. <u>218-09-0190</u>
17. INFORMANT AND ADDRESS <u>Marie E. Ward 3026 Meridene Pk</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
16. Immediate cause (a) <u>Cardiac Arrest.</u>			<u>Jan 55</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>To liver, bone & glands.</u>		(b) <u>Carcinoma Lung, generalized metastasis -</u>	<u>March 55</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7 ch, 1955, to 25 March, 1955, that I last saw the deceased alive on 25 March, 1955, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE Hermon E. Ward MD ADDRESS Sykesville, Md DATE SIGNED 25 March 55

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Mar 28-1955 NAME OF CEMETERY OR CREMATORY West Claret LOCATION (City, town, or county) Baltimore, Md (State) Md

DATE REC'D BY LOCAL REG March 30, 1955 REGISTRAR'S SIGNATURE John B. Loughran 24. FUNERAL DIRECTOR F. B. Mappert ADDRESS 1300 Eastern Blvd

EDWARDS V. S.

APR

1

2761

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. (2749)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 192

1. PLACE OF DEATH:

COUNTY **Howard**

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN **Ellicott City (rural)**

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Frederick Road R F D 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Howard**

CITY (If outside corporate limits write RURAL and give nearest town) OR

TOWN **Ellicott City rural**

STREET ADDRESS

(If rural, give location)

R F D 2 Frederick Road

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

MARGARET**J****MILLER**

4. DATE OF DEATH

(Month)

(Day)

(Year)

3-16-1955**19**

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

10-24-1875

9. AGE last birthday:

79

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

At Home

10b. KIND OF BUSINESS OR INDUSTRY:

None

11. BIRTHPLACE (State or foreign country):

Woodbine, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

James Tovey

14. MOTHER'S MAIDEN NAME:

Alice V. Pickett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

August Miller, Ellicott City, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1**Immediate cause**

(a) DUE TO

Coronary Thrombosis**Antecedent cause(s)****Diseases or conditions, if any, giving rise to the above cause stating underlying cause last**

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
15 min.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

None

19b. MAJOR FINDING OF OPERATION:

None

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

George E. Bunting, M.D.
Ellicott City, MdCHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.DATE SIGNED
3-17-55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

3-19-1955

NAME OF CEMETERY OR CREMATORY

Loudon Park

LOCATION (City, town, or county)

Baltimore, Md

(State)

DATE REC'D BY LOCAL REG.

March 19, 1955

REGISTRAR'S SIGNATURE

Alice to. Bell
per E. J. Spaulding

24. FUNERAL DIRECTOR

F.C. Higinbotham, Ellicott City, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

2762

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City</u> <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Manor Lane</u>		STREET ADDRESS <u>Manor Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>EDWARD LEO O'DONNELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 8, 1955</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>4-26-1869</u>
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James O'Donnell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Naddy</u>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mary Klein, Ellicott City, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
42 Immediate cause (a) <u>Arteriosclerotic Cardio-Vascular Disease</u>		<u>2 years</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1, 1953, to 3/8, 1955, that I last saw the deceased alive on 3/2, 1955, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-11-55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>	LOCATION (City, town, or county) (State) <u>Clarksville</u>
DATE REC'D BY LOCAL REG. <u>Mar. 11, 1955</u>	REGISTRAR'S SIGNATURE <u>John L. Laughlin</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2763

CERTIFICATE OF DEATH

02751

Reg. Dist. No. 191

Items 11, 12 Film 04-18-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Howard		STATE Maryland		COUNTY			
CITY OR TOWN Ellicott City		LENGTH OF STAY (in this place)		CITY OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor		STREET ADDRESS 312 Park Avenue					
3. NAME OF DECEASED (Type or Print) Yee Ho On				4. DATE OF DEATH March 7, 1955			
5. SEX Male		6. COLOR OR RACE Yellow		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 79 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook		10b. KIND OF BUSINESS OR INDUSTRY restuarant		11. BIRTHPLACE (State or foreign country) China California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 9		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hypertensive cardio-vascular disease							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/29 , 19 55 , to 3/7 , 19 55 , that I last saw the deceased alive on 3/5 , 19 55 , and that death occurred at 10 P.M. , from the causes and on the date stated above.							
SIGNATURE Robert B. Taylor				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 3-8-55		NAME OF CEMETERY OR CREMATORY WahWingSangFuneral Home		LOCATION (City, town, or county) (State) 26 Mulberry St., New York, N.Y.	
24. REC'D BY REGISTRAR 3/22/55		REGISTRAR'S SIGNATURE John Lougherans		25. FUNERAL DIRECTOR'S SIGNATURE Earl B. Wolverton		ADDRESS Funeral Home	

BUREAU 18

MAR 22 1955

FILE

2764

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

COUNTY Howard MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Rural Laurel LENGTH OF STAY (in this place) Many Years
 TOWN Rural Laurel
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Scaggsville

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Howard
 CITY (If outside corporate limits, write RURAL and give nearest town) Rural Laurel
 TOWN Rural Laurel
 STREET ADDRESS (If rural give location) Scaggsville

3. NAME OF DECEASED:

(First) John (Middle) Helean (Last) Robey

4. DATE OF DEATH:

(Month) March (Day) 1 (Year) 1955

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

December 13, 1886

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

68 yrs. Months 0 Days 0 Hours 0 Min. 0

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

mail carrier

10b. KIND OF BUSINESS OR INDUSTRY:

U.S. Gant

11. BIRTHPLACE (State or foreign country):

Burtonville, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John T. Robey

14. MOTHER'S MAIDEN NAME:

Clara Shash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

217-32-1831

17. INFORMANT & ADDRESS:

Mrs. Eliza Robey, Laurel, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

903.0

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Virus PneumoniaFractured L. FemurGeneralized Arteriosclerosis

Interval Between Onset And Death

4 days1 yr.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Generalized Hypertrophic Arthritis

20. AUTOPSY

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 3 13 54 10 AMINJURY OCCURRED While at Work ☐ Not While At Work ☒

HOW DID INJURY OCCUR?

Slipped and fell in floor22. I hereby certify that I attended the deceased from 9/22, 1937, to 3/1/55, 1955, that I last saw the deceasedalive on 2/28, 1953, and that death occurred at 8:45 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar 3-55 Shankshileyde Witt Hamilton, Laurel, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 9 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02753

2765

CERTIFICATE OF DEATH

Reg. Dist. No. 191.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Ellicott City, Md.</u>		<u>7 yrs.</u>		<u>Ellicott City, Md.</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>100</u>				<u>Frederick + Ligon Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>WALTER CLARENCE RODGERS</u>				<u>March 8, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 MRS.	
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>July 23, 1873</u>	<u>81</u> yrs.	<u>7</u> Months	<u>16</u> Days	<u>Hours</u> <u>Min.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Supt. Bldg. + Grounds</u>				<u>Balt. City College</u>		<u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
<u>U. S. A</u>							
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Fred. Rodgers</u>				<u>Mary Durham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>None</u>			
17. INFORMANT & ADDRESS:							
<u>4502 Old Fred Rd. Walter L. Rodgers</u>				<u>apt. B</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE				<u>1 month</u>			
ANTECEDENT CAUSE (S)				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>years</u>			
(A) <u>congestive heart failure</u>				<u>3 months</u>			
DUE TO							
(B) <u>myocardial ischemia</u>							
DUE TO							
(C) <u>atherosclerosis</u>							
DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>central thrombosis</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>none</u>				<u>—</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>12-2-</u> , 1954 to <u>3-8-</u> , 1955, that I last saw the deceased alive on <u>2-1-</u> , 1955, and that death occurred at <u>3 P. M.</u> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Donald E. Terhune M.D.</u>				<u>Ellicott City, Md. 3-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Baltimore</u>			
DATE REC'D BY LOCAL REGISTRAR				LOCATION (City, town, or county) (State)			
<u>March 11, 1955</u>				<u>Baltimore Md.</u>			
REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR			
<u>John B. Longhman Jr.</u>				<u>Boston, Sons</u>			
ADDRESS							
<u>608 Fred Ave.</u>				<u>Eastonsville 28, Md.</u>			

BUREAU V. S.

MAR 14 1969

RECEIVED